		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026286

Facility Name: Holy Family Health Center

Address: 2380 East Dempster (Number) Des Plaines (City) 60016 (Zip Code)

County: Cook

Telephone Number: 847 296-3335 **Fax #** 847 296-2027

IDPA ID Number: 363121158001

Date of Initial License for Current Owners: 5/1/1981

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Effie Galetsis **Telephone Number:** 312 207-1040

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) SEE ACCOUNTANT'S COMPILATION REPORT
(Firm Name & Address) Blackman Kallick Bartelstein, LLP, 300 South Riverside Plaza, Chicago, IL 60606
(Telephone) 312 207-1040 Fax # 312 207-1066

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	260	94,900	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	362	TOTALS	362	132,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	86		9,833	9,919	8
9	SNF/PED					9
10	ICF	34,790	30,856	6	65,652	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,876	30,856	9,839	75,571	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.19%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/1/81

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 5/1/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 51 and days of care provided 8,018

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 01/01/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary											1
2	Food Purchase		1,027,199		1,027,199		1,027,199	(19,435)	1,007,764			2
3	Housekeeping	335,076	42,919		377,995		377,995		377,995			3
4	Laundry	189,414	46,105		235,519		235,519		235,519			4
5	Heat and Other Utilities			263,508	263,508		263,508	(4,924)	258,584			5
6	Maintenance	160,314	51,233	58,026	269,573		269,573	(1,134)	268,439			6
7	Other (specify):* Security	42,386			42,386		42,386		42,386			7
8	**TOTAL General Services**	727,190	1,167,456	321,534	2,216,180		2,216,180	(25,493)	2,190,687			8
	B. Health Care and Programs											
9	Medical Director		59	70,000	70,059		70,059		70,059			9
10	Nursing and Medical Records	3,998,401	152,587	44,731	4,195,719		4,195,719		4,195,719			10
10a	Therapy	418,562	14,576	91,778	524,916		524,916		524,916			10a
11	Activities	222,049	3,023	9,065	234,137		234,137		234,137			11
12	Social Services	59,181		2,100	61,281		61,281		61,281			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,698,193	170,245	217,674	5,086,112		5,086,112		5,086,112			16
	C. General Administration											
17	Administrative	262,753	16,714	141,916	421,383		421,383	(100,340)	321,043			17
18	Directors Fees											18
19	Professional Services			24,307	24,307		24,307		24,307			19
20	Dues, Fees, Subscriptions & Promotions			41,583	41,583		41,583	(16,665)	24,918			20
21	Clerical & General Office Expenses	233,374	85,436	38,114	356,924		356,924	(2,140)	354,784			21
22	Employee Benefits & Payroll Taxes			1,004,688	1,004,688	58,781	1,063,469		1,063,469			22
23	Inservice Training & Education			3,414	3,414		3,414		3,414			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			178,173	178,173	(58,781)	119,392		119,392			26
27	Other (specify):* Non-allowable costs			3,100	3,100		3,100	(3,100)				27
28	**TOTAL General Administration**	496,127	102,150	1,435,295	2,033,572		2,033,572	(122,245)	1,911,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,921,510	1,439,851	1,974,503	9,335,864		9,335,864	(147,738)	9,188,126			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holy Family Health Center #0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			427,016	427,016		427,016	(1,866)	425,150			30
31	Amortization of Pre-Op. & Org.			19,392	19,392		19,392		19,392			31
32	Interest			269,864	269,864		269,864	(72,586)	197,278			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			716,272	716,272		716,272	(74,452)	641,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		369,190		369,190		369,190		369,190			39
40	Barber and Beauty Shops	1,175			1,175		1,175		1,175			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,285	198,285		198,285		198,285			42
43	Other (specify):* Lab/Radiology			22,315	22,315		22,315		22,315			43
44	**TOTAL Special Cost Centers**	1,175	369,190	220,600	590,965		590,965		590,965			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,922,685	1,809,041	2,911,375	10,643,101		10,643,101	(222,190)	10,420,911			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(19,435)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(72,586)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(119)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(263)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,100)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,402)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,021)	21		28
29	Other-Attach Schedule See Schedule 5a	(7,924)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,850)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(100,340)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (100,340)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (222,190)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Detail lines 29 and 35 of Page 5 starting in C12. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5A**

Holy Family Health Center

ID# **0026286**

Report Period Beginning: **1/1/2001**

Ending: **12/31/2001**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Convent - supplies	$ (575)	6	1
2	Convent - Repairs/Maint	(559)	6	2
3	Convent Electricity	(686)	5	3
4	Convent- Gas	(1,180)	5	4
5	Convent - Water	(3,058)	5	5
6	Convent - Depreciation	(1,866)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(7,924)		49

Sch V	Adj. Summary
Line 1	0
Line 2	(19,435)
Line 3	0
Line 4	0
Line 5	(4,924)
Line 6	(1,134)
Line 7	0
Line 8	(25,493)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	(100,340)
Line 18	0
Line 19	0
Line 20	(16,665)
Line 21	(2,140)
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	(3,100)
Line 28	(122,245)
Line 29	(147,738)
Line 30	(1,866)
Line 31	0
Line 32	(72,586)
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	(74,452)
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(222,190)

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Holy Family Health Center **#** 0026286 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(19,435)	0	0	0	0	0	0	0	0	0	0	(19,435)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,924)	0	0	0	0	0	0	0	0	0	0	(4,924)	5
6	Maintenance	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(25,493)	0	0	0	0	0	0	0	0	0	0	(25,493)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(100,340)	0	0	0	0	0	0	0	0	0	0	(100,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(16,665)	0	0	0	0	0	0	0	0	0	0	(16,665)	20
21	Clerical & General Office Expenses	(2,140)	0	0	0	0	0	0	0	0	0	0	(2,140)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,100)	0	0	0	0	0	0	0	0	0	0	(3,100)	27
28	**TOTAL General Administration**	(122,245)	0	0	0	0	0	0	0	0	0	0	(122,245)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(147,738)	0	0	0	0	0	0	0	0	0	0	(147,738)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Health Center # 0026286 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(1,866)	0	0	0	0	0	0	0	0	0	0	(1,866)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72,586)	0	0	0	0	0	0	0	0	0	0	(72,586)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(74,452)	0	0	0	0	0	0	0	0	0	0	(74,452)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(222,190)	0	0	0	0	0	0	0	0	0	0	(222,190)	45

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of the Holy Family	100			Holy Family Medical C	Des Plaines	Hospital
				Holy Family Health Care Systems		Health System

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	$ 141,916	Holy Family Health Care Systems, Inc.	100.00%	$ 41,576	$ (100,340)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 141,916			$ 41,576	$ * (100,340)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Holy Family Health care Systems, Inc
Street Address: 100 North River Road
City / State / Zip Code: Des Plaines, Il 60016
Phone Number: (847) 297-1800
Fax Number: (847) 1863

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative Expenses	Accumulated Cost			$ 2	$		$ 41,576	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2	$		$ 41,576	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City		x	Refinance		11/10/94	$ 5,623,000	$ 3,985,130	11/10/09		$ 269,864	1
2	Holy Family Medical Center	x		Purchase of facility		5/1/81	1,800,000	1,800,000	Demand			2
3	Holy Family Medical Center	x		Purchase of facility		5/2/81	600,000	600,000	Demand			3
4	Holy Family Medical Center	x		Purchase of facility		5/3/81	600,000	600,000	Demand			4
5												5
	Working Capital											
6	Holy Family Medical Center	x		Working Capital		Various	5,339,335	2,818,749	Demand			6
7	First of America		x	Amortization of Loan Costs		11/10/94					19,392	7
8												8
9	TOTAL Facility Related						$ 13,962,335	$ 9,803,879			$ 289,256	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(72,586)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (72,586)	14
15	TOTALS (line 9+line14)						$ 13,962,335	$ 9,803,879			$ 216,670	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

This Page is N/A

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026286

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 136,250 B. General Construction Type: Exterior Face Brick Frame Steel Number of Stories 6

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 575,266	1
2	Business Use		1984	275,066	2
3	TOTALS			$ 850,332	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	362		1981	1963	$ 5,610,288	$ 153,161	26	$ 153,161	$	$ 5,029,015	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1981	39,944	288	various	288		38,716	9
10	Land Improvements			1982	3,300		15			3,300	10
11	Land Improvements			1983	16,546		various			16,546	11
12	Land Improvements			1985	2,758		various			2,758	12
13	Land Improvements			1987	26,060		10			26,060	13
14	Land Improvements			1991	2,934		8			2,934	14
15	Land Improvements; Repaving dempster lo			1996	6,944	694	10	694		3,818	15
16	Land Improvements: Utility pole			1996	1,908	127	15	127		699	16
17	Building Improvements			1981	30,116	1,503	various	1,503		22,379	17
18	Building Improvements			1982	38,889	1,941	various	1,941		38,467	18
19	Building Improvements			1983	137,540	686	various	686		103,787	19
20	Building Improvements			1984	161,928	8,084	various	8,084		111,185	20
21	Building Improvements			1985	140,002	2,018	various	2,018		140,002	21
22	Building Improvements			1986	74,495	1,510	various	1,510		63,887	22
23	Building Improvements			1987	81,758	5,091	various	5,091		79,212	23
24	Building Improvements			1988	9,477	622	various	622		8,403	24
25	Building Improvements			1989	29,180	1,962	various	1,962		24,533	25
26	Building Improvements			1990	119,639	10,442	various	10,442		97,421	26
27	Building Improvements			1991	209,393	12,221	various	12,221		152,474	27
28	Building Improvements			1992	47,000	4,700	10	4,700		43,750	28
29	Building Improvements			1992	79,513	6,097	various	6,097		57,925	29
30	Building Improvements			1993	55,142	3,941	various	3,941		33,499	30
31	Building Improvements			1993	7,044	470	15	470		3,993	31
32	Building Improvements			1994	86,489	7,515	various	7,515		56,361	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Buidling Improvements #20-4	1995	$ 5,035	$ 458	11	$ 458	$	$ 2,976	37
38	Buidling Improvements #20-5	1995	5,469		5			5,469	38
39	Buidling Improvements #20-5	1995	7,988	1,029	11	1,029		5,900	39
40	Buidling Improvements #20-5	1995	3,648	365	10	365		2,372	40
41	Buidling Improvements #21-4	1995	94,827	8,621	11	8,621		56,036	41
42	Buidling Improvements #21-5	1995	34,922	3,175	11	3,175		20,637	42
43	Buidling Improvements #21-5	1995	1,423	142	10	142		924	43
44	Buidling Improvements #26-4	1995	6,906	460	15	460		2,991	44
45	Buidling Improvements #26-5	1995	6,358	424	15	424		2,756	45
46	Buidling Improvements: Carpeting for facility	1996	43,550	4,355	5	4,355		43,550	46
47	Buidling Improvements: Rudd water heater tank	1996	825	83	10	83		456	47
48	Buidling Improvements: Rekey/Lock/Latches	1996	13,413	894	15	894		4,917	48
49	Buidling Improvements: Upgrade East elevator	1996	35,024	1,751	20	1,751		9,631	49
50	Buidling Improvements: Wall covering in dining room	1996	7,240	724	5	724		7,240	50
51	Buidling Improvements: Phone system and call system	1996	44,556	4,456	10	4,456		24,508	51
52	Buidling Improvements: Remodeling 3rd floor patient rooms	1996	316,547	21,103	15	21,103		116,067	52
53	Buidling Improvements: Tiling of shower room	1996	1,355	68	20	68		374	53
54	Buidling Improvements: Cabinets and shower doors	1996	15,698	785	20	785		4,318	54
55	Double face exterior sign	1997	5,174	517	10	517		2,327	55
56	Refurbish 2404 sign (Business office)	1997	2,428	243	10	243		1,093	56
57	Sealcoating parking lot area	1997	3,804	380	10	380		1,710	57
58	Painting, Wallcovering, tile replacement of nursing station	1997	102,440	6,829	15	6,829		30,731	58
59	Heaters convector	1997	3,240	324	10	324		1,458	59
60	Emergency phones in elevators-West	1997	1,264	126	10	126		567	60
61	Air Dampers - East Building	1997	2,099	210	10	210		945	61
62	Boilers for East Building	1997	4,310	287	15	287		1,292	62
63	Carpeting Room 215	1997	650	130	5	130		623	63
64	Air Handler of West Building	1997	1,450	145	10	145		615	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,789,930	$ 281,157		$ 281,157	$	$ 6,513,607	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,789,930	$ 281,157		$ 281,157	$	$ 6,513,607	1
2	Painting, wallcovering, floor replacement of 2 West station	1998	34,662	2,311	15	2,311		8,089	2
3	Painting, wallcovering, floor replacement of 4 West station	1998	77,327	5,155	15	5,155		18,043	3
4	Painting, wallcovering, floor replacement of 5 West station	1998	76,450	5,097	15	5,097		17,840	4
5	30 Ton Chiller	1998	17,670	1,178	15	1,178		4,743	5
6	Fire Dampers in bath rooms	1998	7,135	476	15	476		1,666	6
7	Repair water main from Department 300	1998	3,887	389	8	389		1,361	7
8	Gutter replacement of east building	1999	6,400	640	10	640		1,600	8
9	Painting, wallcovering, floor replacement of 2 East station	1999	62,793	4,186	15	4,186		10,465	9
10	Replacement of Tran Compressor	1999	7,063	470	15	470		1,175	10
11	Call system upgrade 1 West	1999	33,238	3,324	10	3,324		8,310	11
12	Call system upgrade 3 West	1999	17,274	1,728	10	1,728		4,320	12
13	Painting, wallcovering, floor replacement of 4 West station	1999	2,082	138	15	138		345	13
14	Painting, wallcovering, floor replacement of Physical Therapy	1999	8,665	578	15	578		1,445	14
15	Construction of Parking Lot	2000	227,278	11,364	20	11,364		17,046	15
16	Landscaping	2000	7,208	721	10	721		1,081	16
17	Replace east elevator hydrolift	2000	33,472	2,232	15	2,232		3,348	17
18	Repair decking	2000	7,000	467	15	467		700	18
19	Door replacement	2000	3,035	304	10	304		456	19
20									20
21	Construction of Parking Lot	2001	15,451	407	19	407		407	21
22	2380 Building remodeling	2001	6,985	175	10	175		175	22
23	Freight elevator gate	2001	1,300	43	15	43		43	23
24	Door replacement	2001	3,378	141	12	141		141	24
25	Gas Steamer - connection with Booster	2001	7,507	250	15	250		250	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,457,190	$ 322,931		$ 322,931	$	$ 6,616,656	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,357,217	$ 80,432	$ 80,432	$		$ 1,007,964	71
72	Current Year Purchases	44,479	3,216	3,216			3,216	72
73	Fully Depreciated Assets	687,077					687,077	73
74								74
75	TOTALS	$ 2,088,773	$ 83,648	$ 83,648	$		$ 1,698,257	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1987 Ford Van	1992	$ 5,000	$	$	$		$ 5,000	76
77	Maintenance	1992 Ford F250	1992	18,860					18,860	77
78	Facility	1998 Saturn Wagon	1997	10,891	1,361	1,361			10,891	78
79	See attached schedule 13a			68,838	17,210	17,210			52,727	79
80	TOTALS			$ 103,589	$ 18,571	$ 18,571	$		$ 87,478	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,499,884	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 425,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 425,150	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,402,391	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vacant Lot	$ 37,464	$	$	86
87	Cobvent Land	35,631			87
88					88
89					89
90					90
91	TOTALS	$ 73,095	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 18,116 Description: Copier, $14647; Postage meter, $3469
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C1&3	3312 hrs	$ 71,246	880	$ 34,189	$	4,192	$ 105,435	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		436	17,879		436	17,879	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C1&3	7766 hrs	214,988	933	36,823		8,699	251,811	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				369,190		369,190	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 286,234	2,249	$ 88,891	$ 369,190	13,327	$ 744,315	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 553,086	$ 553,086	1
2	Cash-Patient Deposits	49,879	49,879	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 195,855)	2,682,341	2,682,341	3
4	Supply Inventory (priced at)	11,028	11,028	4
5	Short-Term Investments			5
6	Prepaid Insurance	80,400	80,400	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,376,734	$ 3,376,734	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	923,427	850,332	13
14	Buildings, at Historical Cost	8,293,886	8,457,190	14
15	Leasehold Improvements, at Historical Cost	2,561,173	2,192,362	15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,547,565)	(8,402,391)	20
21	Restricted Funds	1,069,955	1,069,955	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,300,876	$ 4,167,448	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,677,610	$ 7,544,182	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 132,154	$ 132,154	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120,377	120,377	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	327,859	73,842	30
31	Accrued Taxes Payable (excluding real estate taxes)	(44,605)	(44,605)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		13,103	32
33	Accrued Interest Payable	13,103		33
34	Deferred Compensation		254,017	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 548,888	$ 548,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,401,267	6,401,267	39
40	Mortgage Payable	3,985,130	3,985,130	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 10,386,397	$ 10,386,397	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,935,285	$ 10,935,285	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,257,675)	$ (3,391,103)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,677,610	$ 7,544,182	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,637,620)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(128,025)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,765,645)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	507,970	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 507,970	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,257,675)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,292,197	1
2	Discounts and Allowances for all Levels	(3,309,088)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,983,109	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,245,284	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,245,284	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,962	12
13	Barber and Beauty Care	(9,387)	13
14	Non-Patient Meals	19,435	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	490,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	37,593	19
20	Radiology and X-Ray	3,160	20
21	Other Medical Services	224,111	21
22	Laundry	31,316	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 799,092	23
	D. Non-Operating Revenue		
24	Contributions	9,081	24
25	Interest and Other Investment Income***	73,718	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 82,799	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached schedule 19A	40,787	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 40,787	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,151,071	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,216,180	31
32	Health Care	5,086,112	32
33	General Administration	2,033,572	33
	B. Capital Expense		
34	Ownership	716,272	34
	C. Ancillary Expense		
35	Special Cost Centers	392,680	35
36	Provider Participation Fee	198,285	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,643,101	40
41	**Income before Income Taxes (line 30 minus line 40)****	507,970	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 507,970	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,872	2,080	$ 122,353	$ 58.82	1
2	Assistant Director of Nursing	1,646	2,024	51,253	25.32	2
3	Registered Nurses	63,174	69,112	1,648,343	23.85	3
4	Licensed Practical Nurses	14,916	16,587	292,775	17.65	4
5	Nurse Aides & Orderlies	137,715	150,765	1,772,961	11.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	11,079	12,060	313,385	25.99	7
8	Rehab/Therapy Aides	3,277	3,605	43,472	12.06	8
9	Activity Director	2,729	3,128	42,398	13.55	9
10	Activity Assistants	16,044	15,992	155,801	9.74	10
11	Social Service Workers	5,316	5,660	69,532	12.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	13,960	14,956	201,479	13.47	17
18	Housekeepers	34,972	38,101	338,580	8.89	18
19	Laundry	18,390	20,301	186,879	9.21	19
20	Administrator	2,000	2,080	101,249	48.68	20
21	Assistant Administrator	1,928	2,080	125,042	60.12	21
22	Other Administrative	8,831	8,613	168,581	19.57	22
23	Office Manager					23
24	Clerical	22,502	24,517	249,728	10.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,892	3,081	38,874	12.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	363,243	394,742	$ 5,922,685 *	$ 15.00	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	1,040	70,000	L9,C3	36
37	Medical Records Consultant	48	2,016	L10,C3	37
38	Nurse Consultant	23	1,335	L10,C3	38
39	Pharmacist Consultant	240	10,020	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	3,229	L11,C3	44
45	Social Service Consultant	48	2,100	L12,C3	45
46	Other(specify)				46
47	Rehab Consultant	55	2,888	L 10a, C3	47
48					48
49	TOTAL (lines 35 - 48)	1,516	$ 91,588		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	273	$ 11,268	L 10, C3	50
51	Licensed Practical Nurses	570	20,092	L 10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	843	$ 31,360		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sister Elizabeth	Administrator	0	$ 100,829
John Koch	Asst Administrator	0	124,360
Norma Wanner	Admin Secretary	0	37,564
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 262,753

B. Administrative - Other

Description	Amount
Corporate Consulting	$ 141,916
TOTAL (agree to Schedule V, line 17, col. 3)	$ 141,916
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wessels & Pautsch	Legal	$ 100
Katten Muchin Zavis	Legal	354
Ernst & Young	Audit	16,980
Blackman Kallick	Accounting	6,873
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,307

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,557
Unemployment Compensation Insurance	12,498
FICA Taxes	431,092
Employee Health Insurance	331,799
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	36,235
Retirement Plan	127,476
Employee appreciation	6,812
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,063,469

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,075
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscriptions	2,347
Illinois Council on LTC	2,896
Naier	1,450
The Volunteer Center	150
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,918

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
N/A	
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **SEE SCHEDULE 23B**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **20,944** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **198,285**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **19,435**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Holy Family Health Center
Provider # 0026286
12/31/2001

Reclassifications Schedule 5B	**Increase**	**Line**	**Decrease**	**Line**	**Explanation**
Workman's Comp	58781	22	-58781	26	To Reclass workman's comp insurance from general liability to employee benefits

Holy Family Health Center
Schedule 19A
Additional Income

Other Revenue	Amount
Vending Commisions	3576
Miscellaneous	27211
Sisters Maintenance	10000
Total	40787

Holy Family Health Center
Provider # 0026286
Interest Income
12/31/2001

Schedule 19B

Summary of Interest

Description	Acct Numer	Amount	Interest Income
Unrestricted	110100	546680	15728
Unrestricted	110550	4905	0
Unrestricted	110410	1000114	35033
Unrestricted	110410	1000114	21825
Restricted	110400	69841	1131
Total Interest income			73717

Holy Family
Provider # 0026286
12/31/2001

Schedule 23A
Summary of legal fees

Not Necessary since total does not exceed $2500.

Holy Family
Provider # 0026286
12/31/2001

Schedule 23B
Summary of Membership fees

Description	Allowable	Non-allowable	Total
Illinois Council on LTC	2896		2896
Naier	1450		1450
AAA Motor Club		78	78
Chamber of commerce		150	150
ATA		35	35
The volunteer Center of Northwest Chicago	150		150
Total	4496	263	4759

Holy Family
Provider # 0026286
Schedule 13A
Vehicle Depreciation

Description	Model	Year	Cost	Current Depreciation	S/L Depreciation	Life	Accumulated Depreciation	Line Ref
Resident Transport	1998 Dodge Caravan SS with Wheel Chair	1998	38811	9703	9703	4	33960	45
Facility	1998 Dodge 10 Passenger Van	1998	30027	7507	7507	4	18767	45
	Total		68838	17210	17210		52727	